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# Outpatient hospital services payment system

Medicare beneficiaries receive a wide range of services in hospital outpatient departments, from injections to surgical procedures requiring general anesthesia. Spending for these services is growing rapidly, largely because of changes in technology and medical practice that have fostered new services and encouraged shifts in care from inpatient to ambulatory care settings. Outpatient hospital care accounted for about 7 percent of total Medicare spending in 2001, or about $16 billion.[1]

Medicare originally paid hospitals for outpatient care based on their costs. The Balanced Budget Act (BBA) of 1997 almost completely eliminated such cost-based payment by requiring the Centers for Medicare & Medicaid Services (CMS) to develop and adopt an outpatient prospective payment system (PPS), which was implemented in August 2000.

In requiring the outpatient PPS, the Congress also reduced beneficiary copayments for outpatient hospital care. When the BBA was enacted, copayments accounted for about 50 percent of total Medicare payments to hospitals for outpatient care. Under the new payment system, beneficiaries' share of total payments will slowly decline until it reaches 20 percent. In 2003, beneficiaries paid 38 percent of total payments under the outpatient PPS.

Like the payment system for physician services, the outpatient PPS is a fee schedule. It sets payment rates for individual services based on a set of relative weights, a conversion factor, and an adjustment for geographic differences in input prices. The PPS also includes an outlier adjustment for extraordinarily high-cost services and so-called pass-through payments for certain new technologies that are used as inputs in the delivery of services.

Because of uncertainty about the effects of the new system, certain types of hospitals are at least partially protected from financial losses. Cancer and childrens' hospitals are permanently held harmless from losses; small rural hospitals are held harmless through 2005. Other hospitals that experience losses are eligible for partially offsetting payment adjustments through 2003.

## Defining the outpatient hospital products that Medicare buys

Medicare pays for outpatient services based on the individual service or procedure provided, as identified by a Healthcare Common Procedure Coding System (HCPCS) code. CMS classified procedures, evaluation and

[1]Total spending on all hospital outpatient services (those covered by the outpatient PPS as well as those paid under separate fee schedules or based on costs) accounted for $21.6 billion in 2003.

management services, drugs and devices furnished in outpatient departments into about 700 ambulatory payment classifications (APCs). These APCs group items and services that are clinically similar and use comparable amounts of resources. More than 300 of the APCs identify drugs or devices used in conjunction with a procedure. In addition, some new services are assigned to certain "new technology" APCs based only on similarity of resource use. CMS chose to establish new technology APCs because some services were too new to be represented in the data used to develop the outpatient PPS. Services will remain in these APCs for two to three years while CMS collects the clinical and cost data necessary to refine and update the APC classification system. Additional services may be placed in the new technology APCs after review by CMS.

Within each APC, CMS bundles integral services and items with the primary service. For example, the bundle for a surgical procedure includes operating and recovery room services, most pharmaceuticals, anesthesia, and surgical and medical supplies. In deciding which services to bundle and which to pay separately, CMS considered comments from hospitals, hospital suppliers, and others. For example, in response to public comments, CMS separated corneal tissue acquisition, maintenance, and distribution from services requiring corneal tissue. CMS also pays separately for blood, blood products, and plasma-based and recombinant therapies.

Unlike all other services included in the outpatient PPS—for which the unit of payment is the service or procedure provided—partial hospitalizations for psychiatric services are paid on a per diem basis. These intensive outpatient psychiatric services may be provided by a hospital outpatient department or by a community mental health center, and the per diem payment rate represents the expected facility costs for a day of care.

**Setting the payment rates**

Payment rates in the outpatient PPS are intended to cover hospitals' operating and capital costs for the facility services they furnish; professional services (physicians' services provided to individual patients, for example) are paid separately. Outpatient payment rates are determined by multiplying the relative weight for an APC by a conversion factor. Except for the new technology APCs, each APC has a relative weight that is based on the median cost of services in that APC. Services are assigned to a new technology APC based on their expected cost. New technology APCs range from $0–$50 to $9,500–$10,000; the relative weights are set at the midpoint of these ranges.

The conversion factor translates the relative weights into dollar payment amounts. The initial conversion factor was set so that projected total payments—including beneficiaries' copayments—would equal the estimated amount that would have been spent under the old payment methods, after correcting for some anomalies in statutory formulas.

To account for geographic differences in input prices, the labor portion of the conversion factor (60 percent) is adjusted by the hospital wage index.

The outpatient PPS includes four additional payment adjustments: pass-through payments for new technology; outlier payments for high-cost services; hold-harmless payments for cancer, children's and small rural hospitals; and transitional corridor payments that help to limit hospitals' financial losses under the PPS.

In addition to the new technology APCs, the pass-through payments are a second way that the outpatient PPS accounts for new technologies. Unlike the new technology APCs, however, pass-through payments are not payments for individual services. Instead,

they are payments for certain new technology items—drugs, biologicals, and implantable devices—that are used in the delivery of services. By supplementing the payments for individual services, pass-through payments are meant to help ensure beneficiaries' access to new technologies that are not well represented in data that CMS uses to set the PPS payment rates. For drugs and biologicals, the payments are based on average wholesale prices. For devices, the payments are based on each hospital's costs (as determined by adjusting its charges using a cost-to-charge ratio). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) prevents the Secretary from using a functional equivalence standard for setting pass-through payment rates.

By law, total pass-through payments are limited to 2.0 percent of total payments under the outpatient PPS in 2004 and beyond, and the conversion factor is reduced by 2.0 percent to finance them. If CMS projects that pass-through payments will exceed this limit during a year, the agency is required to reduce all pass-through payments in that year by a uniform percentage to meet the limit. However, CMS did not maintain budget neutrality from August 2000 to April 2002.

Outlier payments are made for individual services or procedures with extraordinarily high costs, compared with the payment rates for their APC group. In 2004, outliers are defined as services with costs that exceed a threshold equal to 2.6 times the PPS payment rate. Hospitals will be reimbursed for 50 percent of the difference between the threshold and the cost of the service in 2003. Aggregate outlier payments are limited to 2 percent of total payments; outlier payments are financed by reducing the conversion factor by 2 percent.

Certain classes of hospitals, such as cancer, children's, and some rural hospitals, are held harmless from financial losses under the PPS. These hospitals are paid according to the PPS payment rates. If their PPS payments are lower than those they would have received under previous policies, however, they will receive extra payments to make up the difference. The Balanced Budget Refinement Act of 1999 (BBRA) mandated permanent hold harmless protection for cancer hospitals and for the outpatient departments of small rural hospitals (100 or fewer beds) through 2003. In addition, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) granted permanent hold harmless protection to children's hospitals. Recently, the MMA extended the protection for small rural hospitals through 2005 and provided hold-harmless payments to all sole community hospitals, regardless of size. The Secretary also will study the costs of rural and urban hospitals to determine if an adjustment is necessary. From the inception of the PPS through 2003, hospitals that did not have hold-harmless status were eligible for less generous transitional corridor payments if their payments under the PPS were less than they would have been under previous payment policy.

To smooth the way to the outpatient PPS, the Congress mandated transitional corridor payments that were allowed to lapse in 2004. The amount of these payments depended on the difference between a hospital's PPS payments and what it would have received under the previous payment policy. Corridor payments were intended to make up a high proportion of hospitals' small losses, but a declining proportion of larger losses. For example, in 2000 and 2001, corridor payments made up 80 percent of losses that were less than 10 percent of what the hospital would have received under previous policy, but only 70 percent of losses in the 10 to 20 percent range. In 2002 and 2003, the transitional corridor payments made up declining proportions of hospitals' revenue losses under the PPS.

The APC groups and their relative weights are reviewed and revised annually. The review considers changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information. CMS is required to consult with a panel of outside experts as part of this review. CMS also annually updates the conversion factor by the hospital market basket index unless the Congress stipulates otherwise.

**Additional changes in the Medicare outpatient PPS**

The MMA introduced several changes to how drugs are paid for under the outpatient PPS. The legislation enacted a floor under the payment rates for drugs in 2004 and 2005 that is tied to the average wholesale price (AWP) as of May 1, 2003. The floor depends on the type of drug:

- In 2004, the floor for sole source drugs, which includes all biologicals, will be 88 percent of the AWP. In 2005, the floor for these drugs will be 83 percent of the AWP;
- In 2004 and 2005, the floor for innovator multiple source drugs will be 68 percent of the AWP; and
- In 2004 and 2005, the floor for non-innovator multiple source drugs, i.e. generic drugs, will be 46 percent of the AWP.

The floor applies to separately paid drugs and biologicals, as well as all drugs and radiopharmaceuticals that were pass-through items in 2001.

The MMA also required payment for drugs to be based on average acquisition cost beginning in 2006, as determined by surveys conducted by the Government Accounting Office in 2004 and 2005 and the Secretary in subsequent years. In addition, the MMA mandated that separate APCs be established for drugs and biologicals costing at least $50 per administration in 2005 and 2006 and excluded separately paid drugs and biologicals from outlier payments. The government will study whether APCs for separately paid drugs should be adjusted to take into account overhead and related expenses.